Section 5: Prioritization of Populations and Interventions

Updated: September 2000

Prioritization of Populations

Because the District of Columbia has a very high prevalence of AIDS cases — 189 cases per 100,000 population, compared with 17.6 cases per 100,000 population nationally — all people who practice behaviors that could lead to the transmission of HIV are at high risk for contracting HIV. Because of limited resources, populations must be ranked in order of highest need as a guide to determining how prevention funding will be prioritized.

In 1999, The Program Initiatives Subcommittee of the HIV Prevention Community Planning Committee (HPCPC) met twice a month for six months to develop the model for priority-setting and rank populations from highest to lowest need for prevention interventions. Members of the Program Initiatives Subcommittee based their decision-making upon eight factors, and assigned a weight to each factor, with 3 having the highest weight:

1. Size of population (3)
2. HIV seroprevalence (3)
3. Riskiness of population behavior (2)
4. Prevalence of risky behavior in the population (3)
5. Difficulty of meeting need (2)
6. Multiple risk factors (3)
7. Emerging issues (1)
8. Resources already targeting the population (2)

How information was gathered and used for each of the eight factors

Size of population: The size of most populations was obtained from the 1997 US Census Bureau estimates of District of Columbia population. Other sources of information included the 1999 HIV/AIDS Epidemiologic Profile of the District of Columbia and reports from the State Center for Health Statistics, the Addiction Prevention and Recovery Administration and the D.C. Department of Corrections In some cases subcommittee members used "best-guess" estimates.

Populations Groups by Rank	Population Estimate	Source for Population Estimate
Injection Drug Users/Substance Abusers	65,000	Addiction Prevention and Recovery Administration
Black Gay/Bisexual Men	11,574	10% of 1997 US Census Bureau estimate of Black men in the District of Columbia (15 or older)
White Gay/Bisexual Men	7,928	10% of 1997 US Census Bureau estimate of white men in the District of Columbia (15 or older)
Black Heterosexual Women	130,438	90% of 1997 US Census Bureau estimate of Black women in the District of Columbia (15 or older)

Incarcerated	5,176	D.C. Department of Corrections
Black Heterosexual Men	104,167	90% of 1997 US Census Bureau estimate of Black men in the District of Columbia (15 or older)
Homeless	10,114	Community Partnership for Prevention of Homeless
Adolescents and Young Adults	57,544	1997 US Census Bureau estimate of men and women 15 to 24 in the District of Columbia
Gay/Bisexual Men of Color	2,122	10% of 1997 US Census Bureau estimates of Hispanic/Latino and Asian and Pacific Islander men in the District of Columbia (15 or older)
People Living With HIV	11,700 to 17,100	HIV/AIDS Epidemiologic Profile of the District of Columbia, 1999
Commercial Sex Workers	NA	NA
Chronically Mentally Ill	10,000	Commission on Mental Health
Hispanic/Latina Heterosexual Women	12,682	90% of 1997 US Census Bureau estimate of Hispanic/Latina women in the District of Columbia (15 or older)
Ex-Offenders	NA	NA
Hispanic/Latino Heterosexual Men	14,112	90% of 1997 US Census Bureau estimate of Hispanic/Latino men in the District of Columbia (15 or older)
Deaf/Hearing Impaired	25,214	1990 Census
Disabled (blind/physical)	40,047	1990 Census
Pregnant Women	8,377	Report from the State Center for Health Statistics on the number of births in DC in 1995.

HIV seroprevalence: The 1999 HIV/AIDS Epidemiologic Profile of the District of Columbia was the source of information for this factor.

Population	**HIV prevalence**
Black male IDUs attending an STD clinic	27%
White male IDUs attending an STD clinic	15%
Hispanic male IDUs attending an STD clinic	11%
MSM attending an STD clinic	15%

The following were estimated by dividing the estimated number of individuals from each population who are living with HIV (from the Epidemiologic Profile) by the US Census Bureau estimates of the adult/adolescent population in DC as of 1997.	
White women	0.2%
White men	3.4%
Black women	1.7%
Black men	6%
Asian and Pacific Islanders and Native Americans	0.8%
Hispanic/Latina women	1%
Hispanic/Latino Men	8.9%

Riskiness of population behavior: Not all acts are equally effective in transmitting HIV. Therefore, an estimation of the riskiness of each act was needed. Because there is little information available on the riskiness of behavior, the Program Initiatives Subcommittee reviewed the work done by the San Francisco HIV Prevention Planning Group (PPG) in developing the 1997 San Francisco HIV Prevention Plan, and agreed to adopt the estimates of relative risk included in that document. To reach its conclusions, the San Francisco PPG reviewed studies from and interviewed researchers in San Francisco, New Jersey and Italy and an article in the British Medical Journal. Based on this review the PPG estimated the relative risk of several behaviors as follows:

Act	**Relative Risk**	**Act**	**Relative Risk**
Sharing unsterile needles	**12**	Giving unprotected fellatio	**1**
Unprotected anal receptive intercourse	**9**	Giving unprotected cunnilingus	**0.5**
Unprotected vaginal receptive intercourse	**3**	Getting unprotected fellatio	**0.1**
Unprotected anal insertive intercourse	**2**	Getting unprotected cunnilingus	**0.1**
Unprotected vaginal insertive intercourse	**1.5**		

The number "3" for vaginal receptive intercourse was chosen arbitrarily by the PPG as the baseline from which the other behaviors were compared and assigned a risk rate relative to that number. For example, much of the literature on risk estimates indicate that sharing unsterile needles is four times riskier than vaginal receptive intercourse, so its relative risk score is 12.

Prevalence of risky behavior in the population: Because there is little information available on the prevalence of risky behavior in high-risk populations in the District, the Program Initiatives Subcommittee adopted the information developed by the San Francisco PPG. That information, which was gathered from a review of 30 studies and "best-guess" estimates by PPG members, was used to determine the average number of times that population groups engaged in risky behaviors annually. Currently the District is conducting studies on the prevalence of risky behavior in several at-risk populations. The following table shows how the San Francisco PPG estimated the annual frequency of risky behavior by population groups.

Population groups and behavior	Estimated annual frequency of behavior
Injection Drug Users	
Sharing unclean needles	39
Gay/Bisexual Men	
Unprotected receptive anal intercourse	21
Unprotected insertive anal intercourse	21
Receiving fellatio, unprotected	37
Giving fellatio, unprotected	9
Heterosexual Men	
Unprotected insertive vaginal intercourse	82
Unprotected insertive anal intercourse	6
Receiving fellatio, unprotected	42
Giving cunilingus, unprotected	41
Heterosexual Women	
Unprotected receptive vaginal intercourse	77
Unprotected receptive anal intercourse	6
Giving fellatio, unprotected	48
Receiving cunilingus, unprotected	35

Difficulty of meeting need: The Comprehensive HIV Prevention Plan section on Population Specific Prevention Needs (Section 3) provided the information for this factor.

Multiple risk factors: The Subcommittee considered several co-factors that can increase the risk for HIV. But because of the scarcity of information on such co-factors as poverty, a history of childhood sexual abuse, social support, mental health stressors and self-esteem for most of the at-risk populations, the subcommittee centered its discussions on the prevalence of sexually transmitted diseases in those populations profiled in the 1999 Epidemiologic Profile of the District.

Emerging issues: The 1999 HIV/AIDS Epidemiologic Profile of the District of Columbia and Section 3 of the Comprehensive HIV Prevention Plan (Population Specific Prevention Needs) provided information for this factor.

Resources already targeting the population: Information for this factor was obtained from Section 4 of the Comprehensive HIV Prevention Plan (Resource Inventory and Gap Analysis).

The averaging of scores resulted in initial target population rankings that were reflective of the standard demographics (i.e., sex, race, sexual orientation and modes of transmission) but not reflective of the epidemiologic data. The Subcommittee then decided to include a ninth factor, the number of AIDS cases reported for each population from 1995 to 1998, that would have the greatest weight.

Any target population representing more than 2% of AIDS cases between 1995-1998 – as reported in the 1999 HIV/AIDS Epidemiologic Profile of the District of Columbia – would be placed in the highest priority category in rank order. The subcommittee also decided that persons living with HIV/AIDS would immediately follow the populations representing 2% or more of the 1995-1998 AIDS cases. The rest of the rankings were based on the other eight factors/weights.

AIDS cases reported in 1995-1998 by population (NA = Information not available.)

Populations Groups by Rank	**AIDS Cases**
Injection Drug Users/Substance Abusers	1,414
Black Gay/Bisexual Men	1,083
Black Heterosexual Women	387
White Gay/Bisexual Men	418
Incarcerated	278
Black Heterosexual Men	268
Homeless	259
Adolescents and Young Adults (13 to 24 years old)	178
Gay/Bisexual Men of Color	98
People Living With HIV/AIDS	4,171
Commercial Sex Workers	NA
Chronically Mentally Ill	NA
Hispanic/Latina Heterosexual Men and Women	36
Ex-Offenders	NA
Deaf/Hearing Impaired	NA
Disabled (blind/physical)	NA
Pediatric (pregnant women)	NA

The results of the Subcommittee deliberations produced this ranking of at-risk or target populations:

1: IDUs/ Substance Abusers
2: Black Gay/Bisexual Men
3: Black Heterosexual Women
4: White Gay/Bisexual Men
5: Incarcerated Individuals
6: Black Heterosexual Men
7: Homeless Individuals
8: Youth/Young Adults
9: Gay/Bisexual Men Of Color (Hispanics/Latinos and Asian and Pacific Islanders)
10: People Living With HIV/AIDS
11: Commercial Sex Workers
12: Chronically Mentally Ill
13: Hispanic/Latino Men And Women
14: Ex-Offenders
15: Deaf / Hearing Impaired
16: Disabled (Blind/Physical)
17: Pediatric (Pregnant Women)

Recommendations for Future Studies

This prioritization is based on what is currently known about the populations included in the rankings. During its deliberations, the Program Initiatives Subcommittee identified a need for additional studies to gather better data about target populations. The subcommittee identified the following information needs:

- Who are men who have sex with men and inject drugs? Are they gay men who are IDUs? Do we need to look further into same sex risk behaviors of IDUs, i.e. re: sex for drugs?
- Sexual risk behavior of chronically mentally ill adults.
- Better population estimates for several populations, including commercial sex workers, and information on where population groups are concentrated.
- Seroprevalence and risk behaviors among heterosexuals, young gay men and transgendered individuals.
- Local needs assessments for all populations.

The goals and objectives for the next three years, which are included in Section 7: Future Directions, address these issues in general terms. In preparation for updating this plan in two years, AHA and the HPCPC will analyze the most current Epidemiologic Profile to determine what data is needed to update the profile in 2001, including which populations should be the subject of special studies on seroprevalence or behavior. In addition, AHA and the HPCPC will

identify the information needs, information sources and methods that will be used to collect information, and develop a plan to update the Needs Assessment, including the Resource Inventory and Gap Analysis, by 2001.

Prioritization of Interventions

The Program Initiatives Subcommittee met several times between June and August 2000 to re-prioritize interventions for the prioritized populations. To facilitate the process of prioritizing the interventions, staff of AHA's Prevention and Support Services Division prepared a binder with reference materials, which was distributed to subcommittee during the first meeting of the re-prioritization process in June.

Most of the material was also used to update Section 4 of the comprehensive HIV Prevention Plan, Potential Strategies and Interventions, so it can serve as a resource for other HPCPC members as well as for organizations that provide HIV prevention services in the District.. The reference material included:

- A copy of the Academy of Educational Development (AED) publication "Setting HIV Prevention Priorities: A Guide for Community Planning Groups," along with a list of suggested steps to follow in setting priorities for interventions, taken from that publication;
- A list of the intervention types used in the Center for Disease Control and Prevention's (CDC) evaluation guidance **(Page 4.4)**;
- Excerpts from the Prevention Plan section on Population-Specific Prevention Needs with information on the prevention needs of targeted populations **(Page 4.9)**; and
- Excerpts from the Interventions section of the plan with information on the effectiveness of different interventions in modifying risky behavior **(Page 4.27)**;
- A copy of the CDC's "Compendium of HIV Prevention Interventions with Evidence of Effectiveness" **(Page 4.37)**;
- Excerpts from "The Effectiveness of AIDS Prevention Efforts," from the Congressional Office of Technology Assistance;
- A table developed by AHA staff listing different interventions that have been shown to be effective with particular populations, with a list of references indicating what studies had found that those interventions work for those populations **(Page 4.66)**;
- Excerpts from the Prevention Plan section on Interventions with information on the cost-effectiveness of different interventions **(Page 4.75)**.

As part of the review of the intervention priorities, AHA also updated Section 4 to reflect the new CDC descriptions of intervention types and to add a compilation, "Guidance and Standards for HIV Prevention Interventions" **(Page 4.83)**, which collects in one document all local and CDC guidelines regarding the implementation of prevention interventions implemented by AHA and AHA-funded organizations.

The subcommittee reviewed and adopted the steps to follow in setting priorities for interventions suggested in the AED publication, namely:

1. Identify Interventions: The committee decided to use the interventions that were prioritized in 1999 for each target population as a starting point, adding or removing interventions as the process required.

2. Determine Factors: The subcommittee decided to use the factors suggested in the AED publication to set priorities for the interventions.
3. Weight Factors: The Subcommittee agreed to assigned weights and ranks to each factor, and asked AHA staff to prepare scoring instruments for each intervention under consideration for each target population.

At the next meeting, the Subcommittee reviewed the tasks to be undertaken, and reviewed the reference materials as well as a series of handouts describing the tasks. Each handout described a specific task to address and suggestions for proceeding to a next step. Each handout also highlighted a portion of the "grid" that could be used to assist the team in recording individuals decisions and reaching consensus.

Subcommittee members reviewed each step, held discussion and agreed to follow the steps described below to make decisions and prioritize interventions:

1. The subcommittee considered the AED-recommended factors and agreed not to add any additional factors to consider. Subcommittee members then discussed each factor by first understanding each factor as a question:
    - Is the intervention designed for a specific target population?
    - Does the intervention target a specific behavior?
    - How effective is the intervention it in changing behaviors?
    - Does the intervention have a theoretical basis?
    - Is the intervention feasible?
    - Has a cost-analysis of the intervention been conducted?

    The Subcommittee agreed to use these factors, which became the first line of the grid:

Intervention targets population	Targets a specific behavior	Effectiveness in changing behavior	Theoretical basis	Is it feasible?	Cost-effectiveness

2. Subcommittee members then discussed how significant or important each factor would be in determining the effectiveness of each type of intervention, and adopted a scale of 1 to 5 for weighting the factors. Each factor was discussed and compared with the other factors, and a number was assigned to each one to reflect the relative significance or weight for each factor.

Intervention targets population	Targets a specific behavior	Effectiveness in changing behavior	Theoretical basis	Is it feasible?	Cost-effectiveness
Weight: 3	**Weight: 5**	**Weight: 5**	**Weight: 3**	**Weight: 4**	**Weight: 1**

3. The sub-committee members discussed each factor by considering possible responses for each factor. Extended discussion was held on the issue of "feasibility." The sample ranking-

sheet given to the sub-committee suggested three main areas to consider: the **capacity** of local organizations to implement the intervention, the **ability** to implement the intervention in a reasonable amount of time, and the **norms and values** of the target populations.

The Subcommittee reviewed the additional areas suggested in the AED guide – including legality, resources and sustainability of interventions and agreed to use the three areas that were recommended when considering whether the intervention was feasible.

The following "ratings" were agreed upon for each Factor:

Intervention targets population	**Targets a specific behavior**	**Effectiveness in changing behavior**	**Theoretical basis**	**Is it feasible?**	**Cost-effectiveness**
Weight: 3	**Weight: 5**	**Weight: 5**	**Weight: 3**	**Weight: 4**	**Weight: 1**
No; designed for another population Somewhat; designed for a similar population Yes; designed for this population	No: it does not target specific behaviors, attitudes, beliefs, norms or barriers. Yes: it does target specific behaviors, attitudes, belief, norms or barriers.	Low Medium High	No theoretical basis. Yes, well-established theoretical basis.	Does the capacity exist to implement the intervention? Is it practical given the available expertise, funding and implementation time? Is the intervention acceptable to the target population?	Cost analysis has not been performed Cost analysis has been performed

4. The sub-committee then discussed each rating response/question and assigned a numerical weight to each one, ranging from 1 to 5. The following "rating scale" was developed by members to assist in "scoring" each response.

Intervention targets population	**Targets a specific behavior**	**Effectiveness in changing behavior**	**Theoretical basis**	**Is it feasible?**	**Cost-effectiveness**
Weight: 3	**Weight: 5**	**Weight: 5**	**Weight: 3**	**Weight: 4**	**Weight: 1**
No; designed for another population **(1 point)** Somewhat; designed for a similar population **(3)** Yes; designed for this population **(5)**	No: it does not target specific behaviors, attitudes, beliefs, norms or barriers. **(1)** Yes: it does target specific behaviors, attitudes, belief, norms or barriers.**(5)**	Low **(1)** Medium **(3)** High **(5)**	No theoretical basis. **(1)** Yes, well-established theoretical basis. **(5)**	Does the capacity exist to implement the intervention? **(1)** Is it practical given the available expertise, funding and implementation time? **(4)** Is the intervention acceptable to the target population? **(5)**	Cost analysis has not been performed **(1)** Cost analysis has been performed **(5)**

The sample grid was then updated based on the consensus reached by the Subcommittee, and discussed in summary, and the Subcommittee agreed to use it to review each type of intervention recommended for each target population.

The subcommittee then looked at the sample grid (shown below) with a sample population and a sample intervention and were shown how to use the grid in conjunction with the resource materials provided previously, as well as summary sheets developed by the Prevention Division to assist sub-committee members in finding documented evidence of intervention effectiveness and cost-effectiveness.

Sample Grid:

Ranking of interventions for: (population)

Intervention:

	Intervention targets population	**Targets a specific behavior**	**Effectiveness in changing behavior**	**Theoretical basis**	**Is it feasible?**	**Cost-effectiveness**
Weights	**3**	**5**	**5**	**3**	**4**	**1**
	No; designed for another population **(1 point)**	No: it does not target specific behaviors, attitudes, beliefs, norms or barriers. **(1)**	Low **(1)**	No theoretical basis. **(1)**	Does the capacity exist to implement the intervention? **(1)**	Cost analysis has not been performed **(1)**
Ratings						
	Somewhat; designed for a similar population **(3)**	Yes: it does target specific behaviors, attitudes, belief, norms or barriers.**(5)**	Medium **(3)**	Yes, well-established theoretical basis. **(5)**	Is it practical given the available expertise, funding and implementation time? **(4)**	Cost analysis has been performed **(5)**
Ratings						
	Yes; designed for this population **(5)**		High **(5)**		Is the intervention acceptable to the target population? **(5)**	
Ratings						
Rating Subtotals						
Totals (weight X rating)						
			Total:		**Rank:**	

During the month of August 2000, the sub-committee accelerated its meeting schedule to include three additional sessions devoted specifically to the task of prioritizing interventions. The meetings allowed for AHA staff to provide guidance on using the prioritization tools and resource materials, and for members to prioritize interventions for each population through a consensus-building process. The committee practiced utilizing the tools and established a process for reviewing support documentation and the "summary sheets" provided by AHA staff. One sheet was a summary list of cost effectiveness studies; the other sheet summarized the results of studies on the effectiveness of particular interventions organized by population. These sheets became a useful component of the process, as they were utilized as starting points for locating more detailed support for members' selection of interventions for target populations.

Subcommittee members agreed to utilize the next sessions to prioritize each recommended intervention for target populations (in priority order).

In the first August session, the sub-committee members convened to share individual issues, questions and concerns about the process and specific target population needs. Two changes were recommended for the prioritization grid and process that had been previously approved. In discussions about "Feasibility," members determined that more than one rating (or selection) was possible and felt that the range of scores then needed to be adjusted so that total scores for this ranking factor were not inflated in comparison with other factors

The changes would allow for two things: the possibility of more than one selection for that factor and a maximum possible rating of 5 points in that column. The change in ratings was as follows:

Is it feasible?

Does the capacity exist to implement the intervention? **Changed from (1) to (2)**	Is it practical given the available expertise, funding and implementation time? **Changed from (4) to (1)**	Is the intervention acceptable to the target population? **Changed from (5) to (2)**

The following steps were followed at each subsequent meetings of the Subcommittee:

1. **Members held discussions of any individual difficulties or issues with the process:** Some members had trouble locating source documentation on successful interventions for specific target populations. Another issue was identifying sub-sets of populations within target groups not specifically defined by risk category (e.g. youth vs. gay youth, heterosexual youth). Another issue was the extent to which documented effectiveness of an intervention for one target population was applicable to another population.
2. **Members identified populations for which they had difficulty locating information:** AHA staff directed members to source documents, starting with the "summary sheets" and using them as guides to actual documented evidence of effectiveness. Members often requested assistance from other members deemed to be more experienced with a given target population by virtue of their representation or work with that population. Members input was sought specifically with regard to feasibility, especially where there were questions about the acceptability of an intervention by members of a target population.

3. **After, discussing difficult areas, members considered each population separately by order of priority:** Each member in turn shared their ratings column by column, having discussion especially where there was non-concurrence for a rating, but also where members wanted clarification of where evidence of effectiveness had been found. Additionally, where target populations were not defined by risk category but by demographics, social situation or affinity group (e.g. homeless, commercial sex workers), discussion was held -- with particular reference to excerpts from the Needs Assessment section of the HIV Prevention Plan and the epidemiological profile, to identify priority sub-sets of populations to be targeted. AHA staff had developed an internal tool to facilitate staff-guidance for this issue. The tool identified those populations by risk category. For example, the homeless population was identified as mostly Black, male and heterosexual, with a large proportion also being IDUs/substance abusers.

   Subcommittee members gave explicit consideration of risk categories to be targeted within a given population for the following target populations: Youth/Young Adults, Incarcerated, Ex-Offenders, Homeless, Chronically Mentally Ill, Commercial Sex Workers, Persons Living with HIV/AIDS, Deaf/Hearing Impaired and Disabled. Recommended interventions were based on the members' consideration of risk and prevalence of risk within each target population.

4. **Additional interventions were recommended for prioritization as each population was considered:** AHA staff provided guidance on this by locating within resource materials clear evidence of effectiveness of interventions that had not been previously recommended.

   In ranking interventions, the Subcommittee differentiated between street outreach interventions, which include those activities where contacts would be reached via events and on-the-street, and venue-based activities, where outreach takes place inside locations (such as health clinics and bars) where members of a specific target population are likely to convene.

   The subcommittee did not consider ranking needle exchange as an outreach intervention for IDUs, because Congress has prohibited the use of federal or District funds for needle exchange programs. (Currently there is one privately funded needle exchange program in the District.)

5. **Members agreed on a final ratings per ranking factor for each intervention with explicit consideration for evidence of effectiveness:** AHA staff recorded their consensus ratings and later scored each intervention by multiplying the total ratings by the weights indicated in the columns. Members who did not participate in the consensus sessions submitted their grids to AHA staff for comparison analysis later.

By the end of the third session, members were not able to complete all of the rankings by consensus due to lack of additional time and the burden of scheduling an additional meeting. Interventions were ranked by consensus for populations #1 to #11. Grids for the remaining populations (#12 to #17) were collected from each participating member by AHA staff, and the interventions for those populations were then ranked by a tally of the ratings of individual Subcommittee members for each recommended intervention. Rankings were based on absolute total scores; scores were not averaged.

The sub-committee met one more time to review and finalize the priority intervention list. Members were provided a list of ranked interventions for final review, including a review and approval of the scores tallied by AHA staff for populations #12 to #17. During the deliberations for final approval, AHA staff made several recommendations that were approved by the Subcommittee:

- Subcommittee members had recommended the use of print and electronic media as an intervention. But a review of the discussions around this intervention indicated that members felt media should be used as part of a social marketing campaign, not just for health education or public information. Therefore, that intervention was changed to social marketing based on the content of the discussion.
- During the ranking process, the Subcommittee recommended social marketing as the second highest ranked intervention for Population #2, Black Gay and Bisexual Men, based on total scores. AHA staff recommended that other interventions -- individual prevention counseling, prevention case management and outreach -- be ranked higher because they are more effective in changing behavior.
- The Subcommittee agreed that any intervention for populations #1 through #12 than received a score of less than 50 not be recommended, and that any intervention that was considered but not scored also be eliminated from the recommended list of interventions.

The Subcommittee's recommendations were presented to the full HPCPC at the August 31 meeting, and were approved.

Additional Considerations: During the deliberations, Subcommittee members stressed the need to consider two issues in the development and implementation of prevention interventions:

1. The interventions, particularly psycho-educational skills building groups and prevention case management, should address psycho-cultural issues that may not be directly related to HIV but may prevent members of the target population from engaging in safer sex and other healthy behavior consistently. Those include co-factors such as a history of sexual, physical and mental abuse; poverty, homelessness, unemployment, lack of social support, mental health stressors and lack of access to prevention resources due to lack of knowledge of services, language or literacy.
2. The effectiveness of time-limited psycho-educational skills-building groups can be enhanced if participants are linked to follow-up support groups (peer and non-peer-led) that help participants maintain healthy behavior.

Recommended interventions: Following is a list of the populations prioritized in 1999 and the interventions that were prioritized in 2000. After the list is a table summarizes the scores given to each intervention for each population, and the priority order they were assigned after the scores were totaled. Those interventions that scored below 50 points were not recommended.

List of Populations Prioritized by the HPCPC in 1999 and Interventions Prioritized in 2000, in Order of Rank:

Target Population #1: Injection Drug Users/substance Abusers

1. Psycho-Educational Skills Building Groups
2. Street Outreach

Target Population #2: Black Gay/Bisexual Men

1. Psycho-Educational Skills Building Groups
2. Individual Prevention Counseling
3. Prevention Case Management
4. Street Outreach
5. Social Marketing

Target Population #3: Black Heterosexual Women

1. Psycho-Educational Skills Building Groups
2. Individual Prevention Counseling
3. Couples Counseling
4. Street Outreach
5. Social Marketing
6. Venue-Based Outreach

Target Population #4: White Gay/Bisexual Men

1. Prevention Case Management
2. Psycho-Educational Skills Building Groups
3. Street Outreach
4. Social Marketing
5. Venue-Based Outreach

Target Population #5: Incarcerated Persons

1. Psycho-Educational Skills Building Groups

Target Population #6: Black Heterosexual Men

1. Individual Prevention Counseling
2. Psycho-Educational Skills Building Groups
3. Couples counseling
4. Venue-Based Outreach

Target Population #7: Homeless Individuals

1. Individual Prevention Counseling
2. Street Outreach

Target Population #8: Youth/Young Adults

1. Prevention Case Management
2. Psycho-Educational Skills Building Groups
3. Street Outreach
4. Social Marketing
5. Venue-based Outreach

Target Population #9: Gay/Bisexual Men of Color (Hispanics/Latinos and Asians and Pacific Islanders)

1. Psycho-Educational Skills Building Groups
2. Prevention Case Management
3. Street Outreach
4. Venue-based Outreach
5. Social Marketing

Target Population #10: People Living With HIV/AIDS

1. Psycho-Educational Skills Building Groups
2. Prevention Case Management
3. Partner Counseling and Referral Services

Target Population #11: Commercial Sex Workers

1. Psycho-Educational Skills Building Groups
2. Street Outreach

Population #12: Chronically Mentally Ill Persons

1. Prevention Case Management
2. Psycho-Educational Skills Building Groups
3. Workshops and Presentations

Population #13: Hispanic/Latino Heterosexual Men and Women

1. Psycho-Educational Skills Building Groups
2. Street Outreach
3. Venue-based Outreach
4. Workshops and Presentations

Population #14: Ex-Offenders (Formerly Incarcerated)

1. Psycho-Educational Skills Building Groups
2. Workshops & Presentations

Population #15: Deaf/Hearing Impaired

1. Psycho-Educational Skills Building Groups

Population #16: Disabled (Blind/Physical)

1. Psycho-Educational Skills Building Groups

Population #17: Pediatric (Pregnant Women)

1. Prevention Case Management
2. Venue-based Outreach
3. Workshops & Presentations

Scores and Ranking for Interventions

The scores listed in this first table (populations #1 through #11) were arrived at by consensus of members during Subcommittee meetings.

(ILI = Individual-Level Interventions, GLI= Group-Level Interventions, OUT= Outreach, PCM= Prevention Case Management, HC/PI= Health Communication/Public Information, PCRS= Partner Counseling and Referral Services, NS= not scored)

Target Populations (in rank order)	Prioritized Interventions (in rank order)		Score
	Category	Intervention Type	
1. Injection Drug Users	GLI	Psycho-Educational Skills Building Groups	**101**
	OUT	Street Outreach	**95**
	HC/PI	Workshops *(Non-skills-based)* & Presentations	**33**
2. Black Gay/Bisexual Men	GLI	Psycho-Educational Skills Building Groups	**105**
	ILI	Individual Counseling	**101**
	PCM	Prevention Case Management	**85**
	OUT	Street Outreach	**79**
	HC/PI	Print & Electronic Media	**101**
	HC/PI	Workshops *(Non-skills-based)* & Presentations	**39**
	OUT	Venue-based Outreach	**39**
3. Black Heterosexual Women	GLI	Psycho-Educational Skills Building Groups	**105**
	ILI	Individual Counseling	**105**
	ILI	Couples Counseling	**91**
	OUT	Street Outreach	**91**
	HC/PI	Print & Electronic Media	**85**
	OUT	Venue-based Outreach	**81**
	HC/PI	Workshops *(Non-skills-based)* & Presentations	**45**
4. White Gay/Bisexual Men	PCM	Prevention Case Management	**105**
	GLI	Psycho-Educational Skills Building Groups	**105**
	OUT	Street Outreach	**95**
	HC/PI	Print & Electronic Media	**81**
	OUT	Venue-based Outreach	**65**
5. Incarcerated Persons	GLI	Psycho-Educational Skills Building Groups	**101**
	PCM	Prevention Case Management	*NS*

Target Populations (in rank order)	Prioritized Interventions (in rank order)		Score
	Category	Intervention Type	
6. Black Heterosexual Men	ILI	Individual Counseling	**101**
	GLI	Psycho-Educational Skills Building Groups	**97**
	ILI	Couples Counseling	**95**
	OUT	Venue-based Outreach	**81**
	HC/PI	Workshops *(Non-skills-based)* & Presentations	**45**
7. Homeless Individuals	ILI	Individual Counseling	**97**
	OUT	Street Outreach	**91**
	HC/PI	Workshops *(Non-skills-based)* & Presentations	**45**
8. Youth/Young Adults	PCM	Prevention Case Management	**101**
	GLI	Psycho-Educational Skills Building Groups	**101**
	OUT	Street Outreach	**91**
	HC/PI	Print & Electronic Media	**81**
	OUT	Venue-based Outreach	**77**
	HC/PI	Workshops *(Non-skills-based)* & Presentations	**45**
	ILI	Individual Counseling	*NS*
9. Gay & Bisexual Men of Color (Hispanics/Latinos and Asians and Pacific Islanders)	GLI	Psycho-Educational Skills Building Groups	**105**
	PCM	Prevention Case Management	**101**
	OUT	Street Outreach	**95**
	OUT	Venue-based Outreach	**81**
	HC/PI	Print & Electronic Media	**81**
10. Persons Living with HIV/AIDS	GLI	Psycho-Educational Skills Building Groups	**105**
	PCM	Prevention Case Management	**105**
	PCRS	Partner Counseling & Referral Services	**95**
	HC/PI	Workshops *(Non-skills-based)* & Presentations	**45**
11. Commercial Sex Workers	GLI	Psycho-Educational Skills Building Groups	**89**
	OUT	Street Outreach	**91**
	HC/PI	Workshops *(Non-skills-based)* & Presentations	**45**

The intervention listed in this table were ranked based on individual scores submitted by individual members and later confirmed by the full Subcommittee.

Target Populations (in rank order)	Prioritized Interventions (in rank order)		
	Category	**Intervention Type**	**Score**
12. Chronically Mentally Ill Persons	PCM	Prevention Case Management	**314**
	GLI	Psycho-Educational Skills Building Groups	**296**
	HC/PI	Workshops *(Non-skills-based)* & Presentations	**172**
13. Hispanic/Latino Men and Women (Heterosexuals)	GLI	Psycho-Educational Skills Building Groups	**324**
	OUT	Street Outreach	**288**
	OUT	Venue-based Outreach	**194**
	HC/PI	Workshops *(Non-skills-based)* & Presentations	**194**
	HC/PI	Print & electronic Media	*1 score*
14. Ex-Offenders (Formerly Incarcerated)	GLI	Psycho-Educational Skills Building Groups	**340**
	HC/PI	Workshops *(Non-skills-based)* & Presentations	**218**
15. Deaf/Hard of Hearing	GLI	Psycho-Educational Skills Building Groups	**266**
	HC/PI	Print & electronic Media	*1 score*
16. Disabled (Blind/Physical)	GLI	Psycho-Educational Skills Building Groups	**320**
	HC/PI	Print *(Braille)* & Electronic Media	*1 score*
17. Pediatric (Pregnant Women)	PCM	Prevention Case Management	**231**
	OUT	Venue-based Outreach	**204**
	HC/PI	Workshops *(Non-skills-based)* & Presentations	**204**